Mail To:
EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

**PA/SMVA**

**Prior Authorization Specialized Medical Vehicle Attachment**

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

## Recipient Information

| ① Last Name | ② First Name | ③ Middle Initial | ④ Medicaid ID Number | ⑤ Age |
|---|---|---|---|---|
| | | | | |

## Provider Information

| ⑥ Performing Provider's Name | ⑦ Performing Provider's Medicaid Provider Number | ⑧ Performing Provider's Telephone Number |
|---|---|---|
| | | (  )  - |

A. Do you have a current Physician Certification, signed by a physician, physician assistant, nurse midwife, or nurse practitioner documenting the recipient's need for SMV transportation on file for this recipient?

❑ Yes ❑ No

B. Please attach a copy of the prescription for trips that exceed the SMV mileage limit signed and dated by a physician, physician assistant, nurse midwife, nurse practitioner, dentist, optometrist/optician, chiropractor, podiatrist, HealthCheck agency, or family planning clinic.

The provision of services which are greater than, or significantly different from, those authorized may result in non-payment of the billing claim(s).

C. _____ _____

Date Requesting Provider's Signature